Senate Bill 62

By: Senators Hudgens of the 47th, Hawkins of the 49th and Butterworth of the 50th

AS PASSED SENATE

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide certain definitions; to include plan administrators in prompt pay requirements; to provide for penalties; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by revising Code Section 33-23-100, relating to the definition of administrator, as follows:

"33-23-100.

(a) As used in this article, the term:

(1) 'Administrator' means any business entity that, directly or indirectly, collects charges, fees, or premiums; adjusts or settles claims, including investigating or examining claims or receiving, disbursing, handling, or otherwise being responsible for claim funds; ~~and~~ or provides underwriting or precertification and preauthorization of hospitalizations or medical treatments for residents of this state for or on behalf of any insurer, including business entities that act on behalf of ~~multiple~~ a single or multiple employer self-insurance health ~~plans, and~~ plan or a self-insured ~~municipalities~~ municipality or other political ~~subdivisions~~ subdivision. Licensure is also required for administrators who act on behalf of self-insured plans providing workers' compensation benefits pursuant to Chapter 9 of Title 34. For purposes of this article, each activity undertaken by the administrator on behalf of an insurer or the client of the administrator is considered a transaction and is subject to the provisions of this title.

(2) 'Business entity' means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(3) 'Standard financial quarter' means a three-month period ending on March 31, June 30, September 30, or December 31 of any calendar year.

(b) Notwithstanding the provisions of subsection (a) of this Code section, the following are exempt from licensure ~~as~~ so long as such entities are acting directly through their officers and employees:

(1) An employer on behalf of its employees or the employees of one or more subsidiary or affiliated corporations of such employer;

(2) A union on behalf of its members;

(3) An insurance company licensed in this state or its affiliate unless the affiliate administrator is placing business with a nonaffiliate insurer not licensed in this state;

(4) An insurer which is not authorized to transact insurance in this state if such insurer is administering a policy lawfully issued by it in and pursuant to the laws of a state in which it is authorized to transact insurance;

(5) A life or accident and sickness insurance agent or broker licensed in this state whose activities are limited exclusively to the sale of insurance;

(6) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(7) A trust established in conformity with 29 U.S.C. Section 186 and its trustees, agents, and employees acting thereunder;

(8) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code and its trustees and employees acting thereunder or a custodian and its agents and employees acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;

(9) A bank, credit union, or other financial institution which is subject to supervision or examination by federal or state banking authorities;

(10) A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized it to do so, provided that such company does not adjust or settle claims;

(11) A person who adjusts or settles claims in the normal course of his or her practice or employment as an attorney and who does not collect charges or premiums in connection with life or accident and sickness insurance coverage or annuities;

(12) ~~A business entity that acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for whom the insurance laws of this state are preempted pursuant to the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.~~ An insurance company licensed in this state or its affiliate if such insurance company or its affiliate is solely administering limited benefit insurance. For the purpose of this paragraph, the term 'limited benefit insurance' means accident or sickness insurance designed, advertised, and marketed to supplement major medical insurance, specifically: accident

only, CHAMPUS supplement, disability income, fixed indemnity, long-term care, or specified disease; or

(13) An association that administers workers' compensation claims solely on behalf of its members.

(c) A business entity claiming an exemption shall submit an exemption notice on a form provided by the Commissioner. This form must be signed by an officer of the company and submitted to the department by December 31 of the year prior to the year for which an exemption is to be claimed. Such exemption notice shall be updated in writing within 30 days if the basis for such exemption changes. An administrator claiming an exemption pursuant to paragraphs (3) and (4) of subsection (b) of this Code section shall be subject to the provisions of Code Sections 33-24-59.5 and 33-24-59.13.

(d) Obtaining a license as an administrator does not exempt the applicant from other licensing requirements under this title.

(e) Obtaining a license as an administrator subjects the applicant to the provisions of Code Sections 33-24-59.5 and 33-24-59.13.

(f) An administrator shall be subject to Code Sections 33-24-59.5 and 33-24-59.13 unless the administrator provides sufficient evidence that the self-insured health plan failed to properly fund the plan to allow the administrator to pay any outside claim."

SECTION 2.

Said title is further amended by revising Code Section 33-24-59.5, relating to timely payment of health benefits, as follows:

"33-24-59.5.

(a) As used in this Code section, the term:

(1) 'Benefits' means the coverages provided by a health benefit plan for financing or delivery of health care goods or services; but such term does not include capitated payment arrangements under managed care plans.

(2) 'Health benefit plan' means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization subscriber contract, any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy, or managed care plan or self-insured plan; but health benefit plan does not include policies issued in accordance with Chapter 31 of this title; disability income policies; or Chapter 9 of Title 34, relating to workers' compensation.

(3) 'Insurer' means an accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation,

or any similar entity and any self-insured health benefit plan ~~not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.~~, which entity provides for the financing or delivery of health care services through a health benefit plan, the plan administrator of any health plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45 or any other administrator as defined in paragraph (1) of subsection (a) of Code Section 33-23-100.

(b)(1) All benefits under a health benefit plan will be payable by the insurer which is obligated to finance or deliver health care services under that plan upon such insurer's receipt of written or electronic proof of loss or claim for payment for health care goods or services provided. The insurer shall within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt mail or send electronically to the insured or other person claiming payments under the plan payment for such benefits or a letter or electronic notice which states the reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the person so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer in accordance with this chapter. When all of the listed documents or other information needed to process the claim has been received by the insurer, the insurer shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the insured or other person claiming payments under the plan the insurer's reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administrates or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) Each insurer shall pay to the insured or other person claiming payments under the health benefit plan interest equal to ~~18~~ 12 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.

(d) An insurer may only be subject to an administrative penalty by the Commissioner as authorized by the insurance laws of this state when such insurer processes less than 95 percent of all claims in a standard financial quarter in compliance with paragraph (1) of subsection (b) of this Code section. Such penalty shall be assessed on data collected by the Commissioner.

(e) This Code section shall be applicable when an insurer is adjudicating claims for its fully insured business or its business as a third-party administrator.″

SECTION 3.

Said title is further amended in Article 1 of Chapter 24, relating to general provisions concerning insurance, by adding a new Code section to read as follows:

″33-24-59.13.

(a) As used in this Code section, the term:

(1) 'Administrator' shall have the same meaning as provided in Code Section 33-23-100.

(2) 'Benefits' shall have the same meaning as provided in Code Section 33-24-59.5.

(3) 'Facility' shall have the same meaning as provided in Code Section 33-20A-3.

(4) 'Health benefit plan' shall have the same meaning as provided in Code Section 33-24-59.5.

(5) 'Health care provider' shall have the same meaning as provided in Code Section 33-20A-3.

(6) 'Insurer' means an accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity, which entity provides for the financing or delivery of health care services through a health benefit plan, the plan administrator of any health plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

(b)(1) All benefits under a health benefit plan will be payable by the insurer or administrator which is obligated to finance or deliver health care services or process claims under that plan upon such insurer's or administrator's receipt of written or electronic proof of loss or claim for payment for health care goods or services provided. The insurer or administrator shall within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt mail or send electronically to the facility or health care provider claiming payments under the plan payment for such benefits or a letter or notice which states the reasons the insurer or administrator may have for failing to pay the claim, either in whole or in part, and which also gives the facility or health care provider so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer or administrator disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer or administrator in accordance with this chapter. When all of the listed documents or other information needed to process the claim have been received by the insurer or administrator, the insurer or administrator shall then have 15 working days

for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the facility or health care provider claiming payments under the plan the insurer's or administrator's reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administers or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) Each insurer or administrator shall pay to the facility or health care provider claiming payments under the health benefit plan interest equal to 12 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.

(d) An insurer or administrator may only be subject to an administrative penalty by the Commissioner as authorized by the insurance laws of this state when such insurer or administrator processes less than 95 percent of all claims in a standard financial quarter in compliance with paragraph (1) of subsection (b) of this Code section. Such penalty shall be assessed on data collected by the Commissioner.

(e) This Code section shall be applicable when an insurer is adjudicating claims for its fully insured business or its business as a third-party administrator.″

SECTION 4.

This Act shall become effective on January 1, 2011.

SECTION 5.

All laws and parts of laws in conflict with this Act are repealed.